Cygnet Victoria House

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated Victoria House as requires improvement overall because:

- There had been a negative impact on the rehabilitation ward since the opening of the acute ward. Managers and staff had raised concern about the timeframe in which the ward had been opened. Patients raised concerns about the restrictions placed on the environment after the opening of the acute ward. There had been a significant increase in the use of agency staff to cover the acute ward.
- Blanket restrictions were in place which did not meet the ethos of a rehabilitation environment.
- Care plans did not always reflect patient needs. Where significant risks had been identified there was not always a risk management plan or care plan in place to mitigate these.
- Although a timetable was in place there was little uptake of structured activity and many patients described being bored.
- Staff were not up to date with all mandatory training and were not trained in immediate life support. Supervision rates had decreased since the acute ward had opened.
- Discussions were taking place around discharge but these were not documented in an easily identified format.
- The hospital worked between paper and electronic records and it was not always clear which were the current documents.
- Medicine was not always authorised in line with the Mental Health Act.

However:

- There were enough staff on each shift to ensure the safe running of the hospital. The hospital was in the process of recruiting permanent staff and used regular bank staff where possible. Staff were supported by managers who were visible and approachable.
- Incidents were reported and investigated and lessons were learnt from and shared with staff. Staff were trained in safeguarding and protected patients from abuse.
- Patients had up to date risk assessments and care plans. There was good multidisciplinary working, daily handover meetings were effective and well-structured and attended by all staff.
- The hospital had a full range of disciplines to support patients care and treatment, which included adequate medical cover, psychology, nurses, support workers, occupational therapy and activities. A programme of activities was in place and offered to patients.
- The provider had appointed an experienced hospital manager.

Summary of findings

Contents

Requires improvement

Victoria House

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units;

Long stay/rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to Cygnet Victoria House

Cygnet Victoria House Hospital is an independent hospital which is owned by Cygnet Behavioural Health Limited. The hospital is split into two wards with shared used of dining area, gym and activities room. The hospital had previously been a 32-bed rehabilitation unit but had been changed into two wards since August 2018. The wards were an acute ward for adults of working age and a high dependency rehabilitation ward. Both wards were for men aged 18 years and over, who had a primary diagnosis of mental illness with a secondary diagnosis e.g. challenging behaviour, complex needs or substance misuse.

The acute ward (Albert) provides care and treatment for men who are experiencing an acute episode of mental illness and require an emergency admission. Albert ward currently caters for up to eight patients. The high dependency ward caters for 22 patients.

The patient profile comprised men aged 18 years or over, informal patients, patients detained under the Mental Health Act and patients experiencing an acute episode of mental illness requiring a crisis admission.

Cygnet Victoria House Hospital is registered with the Care Quality Commission to provide the following regulated activities;

Assessment or medical treatment for people detained under the Mental Health Act 1983.

Treatment of disease, disorder or injury.

There have been six previous inspections carried out at Cygnet Victoria House Hospital. The most recent inspection took place in November 2016 when the hospital was rated as good. The acute ward has not previously been inspected.

The ratings in this inspection report relate to the long stay/rehabilitation ward only. The acute ward has not been rated as part of this inspection due to limited ward specific information. The ward had been open two months at the time of the inspection.

Our inspection team

The team that inspected the service comprised two Care Quality Commission inspectors, two Care Quality Commission assistant inspectors, a Care Quality Commission Mental Health Act reviewer, a Care Quality Commission pharmacy inspector and a variety of specialists working as advisors to the Care Quality Commission including a consultant psychiatrist, a social worker and a nurse.

Why we carried out this inspection

We inspected this service as part of our ongoing mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 16 patients who were using the service;
- spoke with the deputy manager and the heads of care for each ward.
- spoke with 15 other staff members; including doctors, nurses, occupational therapist, psychologist and support workers;
- spoke with an independent advocate;
- attended and observed morning handover meetings for each ward.
- collected feedback from 15 patients using comment cards;
- looked at eight care and treatment records of patients:
- carried out a specific check of the medicine management on both wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We received mixed feedback from patients. Patients felt that the regular staff understood their needs and treated them well. However, opinions were mixed on agency staff as patients felt that they did not introduce themselves or make attempts to engage with them.

Most patients had been in the hospital during the changes and the reduction in rehabilitation beds. Patients talked about how this impacted on them. Their concerns centred around three areas: staffing issues, getting out of hospital and the environment including things to do.

Some patients were annoyed that the space and facilities they previously had were no longer available to them.

All patients we spoke with except one told us they were bored or had nothing to do other than watching television and smoking.

Some patients felt they no longer needed to be in hospital and lacked understanding of how they might get discharged. From our conversations with patients we found some patients had lost hope that they would be discharged from hospital.

All the patients said that they felt safe in the hospital.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- Staff were not up to date with mandatory training and were not receiving immediate life support training.
- Patient information was stored between paper and electronic records and current documents were sometimes difficult to locate.
- There were several blanket restrictions in place on patients which we would not expect to find on a rehabilitation ward.

However,

- Ward areas were clean and well maintained. Staff and patients had access to alarms and ligature points had been mitigated against.
- There were enough staff to ensure patient safety and the hospital had adequate medical cover.
- Risk assessments were completed for each patient and these were regularly reviewed. Risks were discussed daily during morning handover meetings.
- Staff reported incidents and understood responsibilities in relation to safeguarding. There was evidence of learning from incidents.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- It was not always clear which were the current care plans and some care plans had not been updated to reflect patient needs.
- Patients having their rights explained under the Mental Health Act were not always recorded.
- There were duplicate copies of medicine forms and not all prescribed medicine had been authorised in line with the Mental Health Act.

However,

- Patients had an assessment of their needs which included meeting physical health needs
- There were a full range of disciplines within the team. This included adequate medical cover, psychologist, nurses, support staff, occupational therapists and activity coordinators.
- The hospital had good links with external teams, such as drug and alcohol teams and community services.

Summary of this inspection

Are services caring?

Good

We rated caring as **good** because:

- Staff treat patients with kindness, dignity and respect.
- Staff understood patient needs and involved them in their care and treatment.

However,

- Patients said that agency staff did not always treat them well and that they did not engage with them.
- There was limited evidence of patient involvement in care plans.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- Patient discharge was being discussed in multidisciplinary meetings and discussion took place with care-coordinators and commissioners. However, this was not clearly documented in a discharge plan.
- Patients had restricted access to certain areas of the hospital due to the opening of the acute ward.
- Patients were not engaging in meaningful activity either inside the hospital or in the community.

However,

- The hospital promoted comfort, dignity and respect.
- Patients knew how to make a complaint and these were handled appropriately.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- There had been a period of instability at the hospital since the opening of the acute ward.
- Staff and patients had expressed concerns and did not feel engaged in the process.
- The hospital was unable to provide ward specific information for staffing, supervision and mandatory training compliance.
- There was high use of agency staff which had led to poor patient satisfaction.
- Staff supervision rates and mandatory training figures had fallen

However,

- The appointment of a new hospital manager who had previously worked at the service had provided some stability to the hospital.

Summary of this inspection

- There was commitment towards continual improvement and innovation.
- There was evidence of learning from incidents, incidents were recorded and investigated. Managers gave feedback via staff briefings.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The mandatory training module included Mental Health Act, Mental Capacity Act and Deprivation of liberty safeguards. At the time of the inspection 64% of staff had completed the training and staff understanding was mixed.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. The hospital had a dedicated Mental Health Act administrator.

The provider had relevant policies and procedures that reflected the most recent guidance and staff had easy access to these on the intranet.

Patients had easy access to information about independent mental health advocacy. A regular advocate visited the service twice a week and was present during the inspection. There were no concerns with the independent mental health advocacy service and the hospital referred all patients to this service. However, we found that information on the local advocacy service not commissioned by the provider was not available.

Staff explained to patients their rights under the Mental Health Act as required by section 132 in a way that they understood. This was done at the time of admission and three-monthly after this. However, we found three records where this was not completed at the time of admission to the hospital. For those patients who frequently refused this information there was no plan in place of how to address this or safeguard the patient. We found one patient had refused this information for 10 months.

Staff ensured that patients could take Section 17 leave (permission for patients to leave hospital) when this has been granted. Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.

Where detained patients had been receiving treatment in hospital for their mental disorder for three months, the responsible clinician requested a second opinion appointed doctor to authorise treatment or had completed a T2 form to authorise treatment. The responsible clinician had changed the treatment plan of some patients and had completed a section 62 form. Section 62 is used while waiting for a second opinion appointed doctor visit or in emergency situations. We found some T2 and section 62 forms did not detail the route of administration for the medication.

Certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised (section 62 or T3) were completed and located in the dispensing room where the prescription charts were located. We found old forms were present with prescription charts which made it difficult to be sure which medication was authorised. This could lead to mistakes when administering medication to patients. We found not all prescribed medication was authorised. This is a breach of the Mental Health Act. We gave feedback of our concerns to the head of care on the first day of our visit.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that 64% of staff had had training on the Mental Capacity Act.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it and knew where to get advice from.

Detailed findings from this inspection

Staff gave patients every possible assistance to make a specific decision for themselves. Staff continuously assessed capacity and where patients lacked capacity they made best interest decisions.

Patients' care and treatment records contained evidence of capacity assessments. These were all related to consent to treatment decisions. The assessments contained clear documentation of the capacity assessment completed and the rationale on the outcome whether a patient was assessed as having or lacking capacity to consent to treatment.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Long stay/ rehabilitation mental health wards for working age adults	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Acute wards for adults of working age and psychiatric intensive care units

Not sufficient evidence to rate

Safe	Not sufficient evidence to rate
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Not sufficient evidence to rate

Safe and clean environment

There was a separate entrance to the acute ward which was located on the ground floor of the hospital. Staff did regular risk assessments of the care environment. Staff had identified and mitigated ligature points and blind spots on the ward. The provider's estates team had an action plan in place for dealing with these issues. Staff did daily checks, health and safety walkarounds and a full check once a month. However, during our tour of the ward environment, we noticed a fire door leading to the garden area had been propped open by staff which potentially placed patients and staff at risk of harm if there was a fire outside.

The ward was for male patients only so there were no issues in relation to same sex accommodation guidance. There were nurse call points in each patients' bedroom.

All areas of the ward were clean, comfortable and well-maintained. Staff adhered to infection control principles which included handwashing.

The service did not have a seclusion room and patients were not secluded in any other room in the hospital. There was a de-escalation room which was well ventilated and included soft furnishings. Staff offered the use of this room to patients as an alternative to their bedroom when they required some time away from the ward. A staff member remained when the de-escalation room was in use. There had not been any incidents requiring seclusion in the two months since the ward opened.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly and kept clean. Equipment was well maintained and had stickers to indicate it was clean and serviced. There was a separate examination room that was well maintained.

Safe staffing

The provider was unable to give a breakdown of staff for each ward. The hospital reported that there was a total of 29 staff employed which included 8.5 whole time equivalent nurses to work across both the acute and rehabilitation wards. The recruitment of an additional nurse was underway at the time of our inspection and there were plans to recruit a further four nurses in January 2019. Another nurse was due to return from maternity leave in May 2019. The acute ward was staffed by regular bank staff. The multidisciplinary team supported both wards.

The average staff sickness absence figures for the hospital in the year prior to our inspection was 4.5% and the average staff turnover for this period was 2.5%.

The ward was reliant on the use of agency and bank staff at the time of our inspection. There was a 34.5% staff vacancy rate. The provider reported bank or agency staff were used to cover 15% of shifts in August 2018 and 29% of shifts in October 2018. The hospital tended to use the same agency and bank staff so they were familiar with the patients and how the ward operated.

Acute wards for adults of wor age and psychiatric intensive care units

Not sufficient evidence to rate

The ward had calculated the staff required to deliver safe care and treatment. During the day, there was one permanent nurse who was also the acting head of care for the ward and three agency support staff. During the night, there was one permanent nurse and two agency support staff.

A full-time doctor worked between the two wards who ensured physical assessments were carried out and monitored ongoing physical health.

Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. Staffing levels allowed patients to have regular one to one time. Staff were carrying out observations in line with the provider policy.

Medical staff

There was adequate medical cover day and night. The ward was using locums to cover the ward until a permanent consultant was recruited. A full time junior doctor supported both wards. An on call rota was in place for out of hours cover and a doctor could attend the service within 30 minutes at other times if there was an emergency.

Mandatory training

Staff were not up to date with their mandatory training. The hospital could not split mandatory training figures for each ward and provided compliance for all staff. The mandatory training compliance figures at the time of our inspection were:

- fire training– 61.5%
- basic life support– 98%
- information governance– 74.4%
- Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards – 64.2%
- Infection control– 73.1%
- Mental Health Act awareness – 68.5%
- Safeguarding - 75%

Staff were not trained in immediate life support. However, staff had completed emergency first aid at work and compliance was 98%. A programme to implement immediate life support training to staff was planned for January 2019.

Assessing and managing risk to patients and staff

Staff did a risk assessment of every patient on admission and updated it regularly, including after any incident. We looked at care records for three of the patients currently residing on the ward and staff had completed a risk assessment within 24 hours of their being admitted. Staff completed daily risk assessments of all patients.

Staff used recognised risk assessment tools. Staff used the provider's own in-house daily risk assessment tool which was similar in its approach to the assessment of risks covered in other recognised tools commonly used within acute wards.

Staff dealt with any specific risk issues, we saw evidence within care records that individual crisis plans had been created for managing situations when patients' risks or behaviours were heightened.

Staff followed policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms.

Informal patients could leave at will and there were posters on noticeboards so informal patients were aware of this.

Since opening in August 2018 there had been no restraints on the ward.

The provider had a restrictive interventions reduction programme in place which was led by the provider's regional operations director and its quality and compliance manager. Staff on the ward complied with the programme and used de-escalation processes such as verbal de-escalation and breakaway techniques to avoid the need for physical interventions.

Clinical staff were trained in management of actual or potential aggression so they knew the correct techniques to be used if physical restraint was necessary.

Safeguarding

Staff received annual mandatory training in safeguarding with 75% of staff up to date. Staff could access online refresher training when required.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They stated the provider had safeguarding and whistleblowing policies and could use observation practice to monitor patients more closely if there were any concerns about how they were being treated.

Acute wards for adults of wor age and psychiatric intensive care units

Not sufficient evidence to rate

Staff could recognise the possible signs of abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm. All incidents and safeguarding concerns were discussed with the acting head of care who was responsible for sending referrals to local safeguarding teams. The acting head of care stated the ward had only been in operation for two months but felt the relationships with local safeguarding teams was good.

A separate area off the wards was used for any visitors including children.

Staff access to essential information

Staff sometimes found it difficult to find information about patients. The ward used a combination of paper and electronic records which meant information was sometimes stored in different places.

We found information about a patient's allergic reaction to a medicine in a paper file. The information was not clearly marked and could possibly be overlooked by staff.

Staff attended daily meetings within the hospital where all essential patient and ward specific information was shared with staff.

Medicines management

Staff followed good practice in medicines management. Medicine was stored safely and only accessible to staff authorised to handle medicines. We saw that controlled drugs were appropriately stored and signed for when they were administered. The hospital manager was the controlled drugs accountable officer. Staff monitored the effects of anti-psychotic medicine upon patients' physical health.

A pharmacy contractor supplied medicines under a service level agreement which included a process for weekly medicines management audits. Audits had identified signatures and general administrative errors such as filing of information which were shared with staff to improve practice.

There were appropriate arrangements in place for recording the administration of patients' medicines. These were clear and fully completed with no gaps. Prescription charts included details about any allergies patients had to medicines. Staff carried out medicine stock checks and reconciled stocks against administration records. Some discrepancies were identified by the pharmacy and during an internal audit but it was unclear what action had been taken to investigate these issues. There had been no incidents where rapid tranquilisation had been administered.

Track record on safety

There had been no serious incidents on the ward since it had opened in August 2018.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Incidents were reported using a paper form. The incident reports were discussed in morning meetings and the acting head of care identified any that required further follow up or investigation. A report was then completed by the acting head of care and sent to the service manager. A reporting tool was then completed by the service manager and sent to the board for monitoring purposes. Administrators logged the types of incident and actions taken onto a database for clinical governance reviews. Any serious incidents were discussed with the operations director who decided if the incident required any external investigation. The main types of incidents on the ward were in relation to substance misuse and aggression.

Staff understood the duty of candour and knew what their responsibilities were under it in relation to being open and transparent, and giving patients and families a full explanation and apology when things went wrong.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Assessment of needs and planning of care

We looked at three patients' care records. Staff completed comprehensive mental health assessments and the physical health of each patient in a timely manner at, or soon after, admission.

Staff developed care plans that met the needs identified during assessment. Patients were asked to complete a

self-assessment form which they used to record their strengths and goals and staff used to develop individualised, holistic and recovery-orientated care and treatment. We saw evidence that care plans were being updated when appropriate.

Best practice in treatment and care

Staff provided a range of care and treatment interventions. Interventions included medicine and psychological therapies. The service had two occupational therapists and three activities coordinators. An activities timetable was available to patients however, uptake was low.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Staff assessed choking risks, staff registered patients with GPs and staff were trained to take bloods and carry out electrocardiograms. The provider also had a physical healthcare policy in place. Staff supported patients to live healthier lives which included advice about healthier food choices and substance misuse and providing patients with access to a gym.

Staff monitored patients' nutrition and hydration needs.

Staff used recognised rating scales to assess and record severity and outcomes. This included the Health of the Nation Outcome Scales, Integrated Clinical Environment system and the Global Assessment of Functioning scale. The service also used the provider's own in-house tool.

Staff were unable to access blood test results online due to difficulty in obtaining an account so medical staff had to ring for the results. The head of care for the rehabilitation ward was attempting to resolve the issue at the time of our inspection.

Staff participated in clinical audits, benchmarking and quality improvement initiatives. These included weekly medicine audits, monthly audits of closed circuit television footage, engagement and observation, health and safety, use of the Mental Capacity Act, searches, quarterly infection control audits, annual ligature audits, safeguarding, suicide risks, surveys and action plan reports.

Skilled staff to deliver care

The team had a range of disciplines to meet the needs of patients on the ward. This included doctors, nurses, support workers, psychologists and occupational therapists.

Staff were experienced and qualified, however, there were some gaps in skills and knowledge as mandatory training figures were below provider compliance rates and staff were not trained in immediate life support. Staff could access specialist training for their role. Staff had undertaken specialist training in substance misuse and management of actual or potential aggression.

Managers provided permanent staff with an appropriate induction using the care certificate standards as the benchmark for healthcare assistants. This included use of the care records system, health and safety, policies and procedures, security, use of observations, safeguarding and other topics.

Managers ensured that staff had access to regular team meetings. We observed a daily morning meeting in progress and noted good interaction between staff and managers and were impressed with the level of information shared amongst the team about patients and ward related issues.

Managers provided staff with supervision which included discussions about morale, performance targets and key performance indicators, incidents, safeguarding, personal support and professional development and appraisal of their work performance.

The average compliance rate for staff supervision was 83% for the 12 months prior to our inspection visit. The figures could not be broken down to the acute ward which had only been open two months. However, the figures for the final two months had decreased: 53% for September and 58% for October 2018 which managers were aware of. The figures provided for staff supervision were combined for both the acute and rehabilitation wards as the provider did not report this data separately at the time of our inspection. The provider reported that 93% of staff had been appraised but were unable to separate figures by ward.

The provider had a performance management system in place which included procedures for managers to follow in relation to addressing poor staff performance promptly and effectively.

Multidisciplinary and inter-agency team work

Acute wards for adults of wor age and psychiatric intensive care units

Not sufficient evidence to rate

Staff held daily, effective multidisciplinary meetings and shared information about patients at handover meetings. Nurse handovers included information about patient risks and there were other staff communications in place such as emails.

The ward had effective working relationships, including good handovers, with other relevant teams within the organisation and external bodies. These included relationships with care coordinators, GPs, social services, advocates, a police drug liaison officer, substance misuse services and the local college.

Adherence to the MHA and the MHA Code of Practice

Staff were required to complete mandatory training in the Mental Health Act and Mental Health Act awareness. However, compliance figures for these training modules were low at the time of our inspection. Only 64% of staff had completed training in the Mental Health Act and only 68% had completed Mental Health Act awareness training. This was having an impact as staff we spoke with were unable to clearly demonstrate their understanding of the Mental Health Act.

Ward staff had access to advice on the use of the implementation of the Mental Health Act and its Code of Practice via a Mental Health Act administrator who worked within the hospital. The administrator also monitored staff compliance with the Act via audits of associated records and papers. Any findings were shared with staff and used to improve practice within the hospital.

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice via the provider's intranet, internet or by speaking to the service's Mental Health Act administrator. The policies and procedures were up to date and in-line with the current legislation and guidance.

Patients had regular access to an independent mental health advocate. An advocate visited the hospital twice a week.

Staff did not always evidence that they had explained to patients their rights under the Mental Health Act within patients' care records.

Staff encouraged patients to take their Section 17 leave when this has been granted and the associated paperwork was correctly completed. There were posters on noticeboards to tell informal patients that they could leave the ward of their own free will.

Staff stored copies of patients' detention documentation and other Mental Health Act documentation correctly so that they were readily available to staff when required.

Good practice in applying the Mental Capacity Act

Staff were required to complete mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, only 64% of staff had completed training in the Mental Capacity Act. This was having an impact as staff we spoke with were unable to clearly demonstrate their understanding of the Mental Capacity Act.

The provider had a policy on the Mental Capacity Act, including the Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it via the provider's intranet.

Ward staff had access to advice on the use of the implementation of the Mental Capacity Act via the hospital's Mental Health Act administrator. The administrator also monitored staff compliance with the Act via audits of associated records and papers. Any findings were shared with staff and used to improve practice within the hospital.

Staff gave patients every possible assistance to make a specific decision for themselves. Staff assessed and recorded capacity consent appropriately. When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Staff invited members of the multidisciplinary team, independent mental capacity advocates, families and carers and the patient to best interests' meetings.

Staff had made no Deprivation of Liberty Safeguards application since the opening of the ward.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Acute wards for adults of wor age and psychiatric intensive care units

Not sufficient evidence to rate

Not sufficient evidence to rate

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with and discussing patients showed that they were discreet, respectful and responsive. Staff provided patients with help, emotional support and advice at the time they needed it. Staff discussed the specific needs of patients individually, and worked together to respond to the daily changing needs of patients. However, when we spoke with patients, they told us that the attitudes and behaviours displayed by the full-time staff were not always shared with agency staff, who were not always as friendly.

Staff supported patients to understand and manage their care, treatment or condition. Patients were discussed daily in morning handover meetings where staff discussed different treatment options that patients could consider moving forward. Discussions took place with patients in ward rounds and one to one time.

Patients said staff treated them well and behaved appropriately towards them. Patients told us that staff were polite, respectful and caring towards them and that they felt that staff were also genuinely interested in their wellbeing. However, patients had differing opinions of agency staff who they felt that they did not always engage or speak to them. The independent mental health advocate confirmed that since the changes to the hospital and the increased use of agency staff that they found not all staff introduced themselves.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. This was reflected within patient care plans that outlined the full range of patient's individual needs, and were personalised to the individual. Staff were aware of the provider Equality and Diversity policy, but were unable to explain how this has been implemented on the ward and in every day practice. Staff were unsure about the availability of different methods of communication e.g. translators, as these had not been required previously on the ward.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Staff were aware of the complaints procedure, as well as the whistleblowing policy. All staff we spoke with said they would feel confident in raising concerns.

Staff maintained the confidentiality of information about patients.

Involvement in care

Staff used the admission process to inform and orient patients to the ward and to the service. Patients were given an information booklet.

Staff involved patients in care planning and risk assessment. Each patient had an individual care plan and these were regularly reviewed. Patients were new to the ward and said they had received a lot of paperwork about the service, they were not sure if this included their care plan.

Staff found effective ways to communicate with patients with communication difficulties. Staff had tried to represent and incorporate patient views into care plans. Patients had completed self assessments that formed parts of their care plan. The completed self assessments that were included in their plans outlined patient's strengths, weaknesses, likes, dislikes and their goals. Patients attended multidisciplinary reviews if they chose to. Patient views were recorded in most care programme approach meeting minutes.

Staff involved patients when appropriate in decisions about the service. The hospital involved patients in staff recruitment and conducted an annual survey, to get feedback about different aspects of the service. This feedback was reviewed by staff members, and informed decisions to be made regarding enhancing and improving the service.

Staff ensured patients could access advocacy.

Involvement of families and carers

Staff informed and involved families and carers where appropriate. Many of the patients were no longer in contact with family. Patients were asked about family involvement when they came into the service and consent was obtained to contact loved ones. A monthly carers clinic was

Acute wards for adults of wor age and psychiatric intensive care units

Not sufficient evidence to rate

available. The clinic gave families and carers the opportunity to ask questions about the hospital, ask about their loved one's treatment and for them to give feedback on the service.

The psychologist took the lead for working with families and carers and was in the process of identifying what support was available. Information was given to families on how to access a carers assessment.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Not sufficient evidence to rate

Access and discharge

The ward had been open since August 2018 and had restricted admissions for the initial few months. The ward had eight beds but at the time of the inspection there were three patients on the ward. Patients were referred directly to the ward or via the referral line. The clinical team carried out a review to determine if the hospital could meet the needs of the individual and manage risks safely. The admission was accepted the same day once all relevant clinical information had been received and reviewed. The acting head of care had the authority to refuse any admissions whose needs could not be safely met on the ward.

There were beds available in a psychiatric intensive care unit if a patient required more intensive care. The provider had its own psychiatric intensive care unit provision and could place people in a setting within their local community so they could maintain contact with the people who mattered to them.

Staff planned for patients' discharge, including good liaison with care managers/co-ordinators.

We saw evidence within patients' care records that staff tried to help patients to access other services. However, two of the three care records we looked at indicated that the patients were refusing offers of help.

The service complied with transfer of care standards by using standard clinical headings in forms and letters in relation to referrals and discharges of patients.

Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms which they could personalise. Patients could store their possessions safely.

Staff and patients had access to a range of rooms and equipment which included a clinic room, activities room, gym and computer space. However, access to the rooms was restricted as they were shared with the rehabilitation patients.

Patient activities were available seven days per week. They included cookery, leisure based activities, pool tournaments, walks in the community and holistic therapy. Patient uptake was low to these activities.

There were quiet areas on the ward and a room where patients could meet visitors. A telephone was available to patients on the ward but most patients had their own mobile phones.

Patients had access to an outside space. This was separate to the outside space used by the rehabilitation ward.

Patients who spoke with us said the food was of a good quality. Patients could make hot drinks and snacks all day.

Staff and patients had access to the full range of rooms and equipment to support treatment and care (clinic room to examine patients, activity and therapy rooms).

Patients engagement with the wider community

Staff supported patients to maintain contact with families and carers and other people who mattered to them. A monthly carers clinic took place where family members were given a timeslot to call the service and discuss any issues or concerns they had. Members of the team were available if there were specific issues the family wanted to discuss.

The provider promoted social inclusion and was working towards reducing the stigma around mental health within the local community. Staff had done presentations around mental health at local nurseries, worked to raise funds for local charities and held open days at local churches.

Meeting the needs of all people who use the service

Acute wards for adults of wor age and psychiatric intensive care units

Not sufficient evidence to rate

Regular community meetings were taking place. The service made adjustments for disabled patients. The ward was on the ground floor, was wheelchair accessible and there was also a lift within the hospital.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. There were posters on noticeboards within the ward. Information was also available in different formats such as easy-read and other languages if required. Patients had access to interpreters and signers when they were needed.

The service could meet the specific dietary needs of patients. Patients completed a dietary requirement form when they were admitted and these were then being catered for.

Patients had access to a multi faith room and the service had links with local services to ensure peoples religious and spiritual needs were met.

Listening to and learning from concerns and complaints

There had been nine complaints made to the hospital in the previous 12 months. Only one of these complaints was upheld which was in relation to a limited variety of food choices. This had been addressed as the hospital had altered the frequency of its meal rotas accordingly. No complaints had been referred to the Ombudsman.

Patients knew how to complain or raise concerns and were given feedback.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to handle complaints appropriately.

Findings from investigations into complaints were shared in team meetings, multidisciplinary meetings and emails and used to improve practice within the ward.

There were posters on noticeboards informing detained patients how to make a complaint about their care and treatment to the Care Quality Commission.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Not sufficient evidence to rate

Leaders had the skills, knowledge and experience to perform their role. They had qualifications in mental health, had received supervision training and championed safeguarding and dignity. The hospital had recently undergone a significant change in management. The impact of this could be seen, however the hospital was regaining some stability with the appointment of a new hospital manager.

Leaders had a good understanding of the service through attendance of daily team meetings and looking at progress towards the hospital's key performance indicators.

Leaders were visible within the hospital and both patients and staff found them approachable.

Leadership development opportunities were available to all staff, including those not currently in management roles. These included an apprenticeship leadership programme and, for support workers with an interest in becoming a nurse, there was access to associate nurse training.

Vision and strategy

The provider's values were honesty, responsibility and respect. The values were displayed on intranet screens and on notice boards. Although permanent staff knew the vision and values, agency staff within the hospital were unaware of them. A booklet was being developed for all new staff including agency.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Staff had the opportunity to contribute to discussions about the strategy for their service.

Culture

Staff felt respected, supported and valued and able to raise concerns without fear of reprisals. Staff felt positive and proud about working for the provider and their team and felt their teams worked well together. However, there had been a significant change to staffing since the opening of the acute ward and previously staff had not felt listened to.

Acute wards for adults of wor age and psychiatric intensive care units

Not sufficient evidence to rate

The provider had a whistleblowing policy which was accessible to all staff. The policy and how to use it was attached to noticeboards and on all staff toilet doors. Staff received training in the whistleblowing policy as part of their e-learning.

Managers dealt with poor staff performance when needed and we saw evidence of where this had taken place. The provider had a performance management policy with procedures for managers to follow in relation to dealing with poor performance.

Staff confirmed that supervision and appraisal sessions contained discussions about their career progression and how it could be supported.

Managers could give examples of where the provider promoted equality and diversity in their day to day work. These included mandatory equality and diversity training for all staff and liaising with local lesbian, gay, bisexual and transgender help groups, a hate crimes police officer. The provider also had a bullying and harassment policy and there were three trained bullying and harassment officers within the hospital. However, when staff were asked how equality and diversity was promoted on a day-to-day basis, they were unable to give specific examples which indicated the provider's equality and diversity initiatives had not been sufficiently communicated.

Staff had access to support for their own physical and emotional needs. An employee assistance helpline and counsellor sessions were available to staff.

The provider recognised staff success through employee of the month and awards to staff. Staff compliments were raised in the morning meetings.

Governance

Not all governance systems were effective in the hospital. Staff were proactive in undertaking audits within the hospital, complaints and incidents were investigated and lessons learned were used to improve practice. However, staff were not up to date with their mandatory training, staff supervision figures were low in September and October 2018, the hospital's care records system made it difficult for staff to access essential information quickly and blanket restrictions were not always justified.

There were daily staff meetings during which essential information, such as learning from incidents and complaints, was shared and discussed. Staff implemented recommendations and lessons learned from reviews and investigations into deaths, incidents, complaints and safeguarding alerts.

Staff understood the arrangements for working with other teams, both within the organisation and with external bodies, to meet the needs of the patients.

Management of risk, issues and performance

Staff maintained and had access to a risk register. Staff had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required.

The service had a business continuity plan in place which included procedures for fires, power failures, gas and water leaks, terrorist attacks and bomb scares, adverse weather conditions, outbreaks of infection, missing persons, loss of information technology and disruption to the supply of food.

The ward had not been asked to make any cost improvements.

Information management

The hospital's administrators and the provider's data analysts collected data from staff and cascaded it when appropriate.

Staff had access to the equipment and information needed to do their work. However, the hospital was working between paper files and an electronic system. Permanent staff knew where information was stored but we found that this could be in several places, was not consistent and there were concerns important information such as allergies to medicine were not adequately highlighted.

Information governance systems included confidentiality of patient records. Paper files were stored in a locked cabinet.

Managers had access to information to support them with their management role in formats such as graphs which meant they had an easy to understand visual display of progress and outstanding issues.

Staff made notifications to external bodies such as local safeguarding teams, the police and the Care Quality Commission when appropriate.

Engagement

Acute wards for adults of wor age and psychiatric intensive care units

Not sufficient evidence to rate

Staff and patients had access to up to date information about the provider through bulletins, noticeboards, meetings and on the intranet. Carers obtained information about the hospital and work of the provider via attending the hospital's monthly carers' clinic.

Patients and carers were involved in decision-making about changes to the service. For example, patients had been involved in the recruitment of staff to the hospital by devising interview questions and being part of recruitment panels.

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback. For example, there was an initiative called the People's Council during which, patients and staff could put questions and suggestions to the operations director to take forward.

Directorate leaders regularly engaged with external stakeholders such as commissioners and Health watch as they were routinely invited and attended care programme approach meetings.

The provider gave patients and carers opportunities to provide feedback on the service they received. The provider conducted annual surveys and managers reviewed the results to identify the areas that needed improvement. The hospital had a patient representative who attended clinical governance meetings to feedback any issues and contribute to how the service could be improved.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation. The hospital's psychologist was the research lead for the organisation.

Staff were participating in research which included mindfulness for staff and a mindfulness tracker for patients. The service was also doing research into the impact the changes to the hospital were having upon staff. The provider had its own research group that was researching the use of chat cafes, engagement with patients and the model of human sociality.

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Innovative practices included the use of eye movement desensitisation and reprocessing. This is a form of psychotherapy in which the person being treated is asked to recall distressing images while generating one type of bilateral sensory input, such as side-to-side eye movements or hand tapping.

The provider used quality improvement methodologies. These included the recruitment of an expert by experience to highlight the patient experience to the board, the development of information technology systems to support the measurement of outcomes of patient care and the development of a nurse preceptorship training programme.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Are long stay/rehabilitation mental health wards for working-age adults safe?

Requires improvement

Safe and clean environment

The ward was a high dependency rehabilitation unit and entrance was through a locked door leading to reception. Visitors let staff know they had arrived by using the telecom system.

The ward layout allowed staff to observe all parts of ward. Bedrooms were located along one corridor with the nursing station at the end.

Staff completed regular risk assessments of the care environment. Potential ligature points had been identified through an audit and gave details of how these were mitigated.

Staff had easy access to personal alarms and patients had nurse call systems in their bedrooms.

All ward areas were clean, had good furnishings and were well maintained. Maintenance support was available on site.

Cleaning records were up to date and demonstrated that ward areas were cleaned regularly.

Staff adhered to infection control principles, including handwashing.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs which staff checked regularly. There was a separate examination room that was well maintained.

Safe staffing

The provider had calculated the minimum staffing levels required to maintain safety and a therapeutic environment. The number of nurses and support staff calculated matched the number on shift.

The hospital reported that there was a total of 29 staff employed to cover both wards, which included 8.5 whole time equivalent nurses to work across both the acute and rehabilitation wards. The recruitment of an additional nurse was underway at the time of our inspection and there were plans to recruit a further four nurses in January 2019. Another nurse was due to return from maternity leave in May 2019.

The average staff sickness absence figures for the hospital for the year prior to our inspection was 4.5% and the average staff turnover for this period was 2.5%.

The manager could adjust staffing numbers dependant on complexity and this was outlined in the staffing analysis. A qualified nurse was present in communal areas at all times.

Staffing levels allowed patients to have regular one to one time with their named nurse.

There were enough staff to carry out physical interventions. However, there had been an incident where a patient had intervened and supported staff to restrain another patient. Staff had dealt with the incident appropriately. The incident had been fully investigated and learning shared with staff.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

There was adequate medical cover day and night. A full-time consultant worked on the ward and was also on call out of hours from Monday until 5pm Friday. Annual leave was covered by medical staff from the providers other services. An on-call rota was in place from 5pm Friday until 9am Monday. The rota included doctors from across the region. A full-time staff grade doctor worked between the two wards and ensured physical assessments were carried out and monitored patients ongoing physical health.

Since the opening of the acute ward training compliance figures had dropped. The hospital was unable to split the figures to ward level. The mandatory training compliance figures at the time of our inspection were:

- fire training– 62%
- basic life support– 98%
- information governance– 74%
- Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards – 64%
- Infection control– 73%
- Mental Health Act awareness – 69%
- Safeguarding – 75%

Basic life support training was 98% of staff had completed emergency first aid training. The provider was implementing an immediate life support programme and all staff were due to be trained in January 2019. However, at the time of the inspection staff were not trained in immediate life support.

Assessing and managing risk to patients and staff

Staff completed a risk assessment of every patient on admission and this was updated every eight weeks or when an incident occurred. The service used the short-term assessment of risk and treatability risk assessment tool. Psychology staff completed their own risk assessment using the historical clinical risk management 20 if required. Psychology staff also used the information from incidents to identify triggers, trends and themes for individual patients. This information was used to complete formulations with patients on their caseload. Staff used a daily risk assessment tool, this was used in daily morning handover meetings.

Staff followed the provider policy for the use of observation and this was recorded. Patients were searched if their risk assessment identified any issues which included any patients suspected of bringing illegal substances into the hospital.

There were several blanket restrictions in place, these are restrictions applied to all patients which are not based on the individual patient's risk assessment. Restrictions included the use of plastic cutlery in the patient kitchen, restrictions on high caffeine drinks, restrictions on lighters and locked bathroom doors. We reviewed the last six months of records from the reducing restrictive practice group and found that these predominately remained unchanged and the entries recorded for each month were the same. The exception was the decision to unlock a toilet and lift the restriction on high caffeine drinks. We found most restrictions had been in place for over one year. We did not see what alternatives had been considered or how the impact of the restriction had been assessed for those patients who did not need this.

Informal patients could leave and we saw information displayed explaining this. There were two informal patients in the hospital at the time of the inspection.

There had been 30 episodes of restraint between 1 April – 30 September 2018 involving seven patients. There had been 14 incidents involving the use of rapid tranquilisation. In two cases where rapid tranquilisation had been used we found that staff were not following the providers policy in relation to physical health monitoring and care planning.

The provider had a restrictive interventions reduction programme in place which was led by the provider's regional operations director and its quality and compliance manager. Staff on the ward followed the programme and used de-escalation processes such as verbal de-escalation and breakaway techniques to avoid the need for physical interventions. The use of physical interventions was monitored in handovers, monthly governance meetings, trends analysis, lessons learned reviews and debriefs with the patients and staff involved.

Safeguarding

Staff were trained in safeguarding, 75% of staff had completed an e-learning module and managers had completed level three. Staff knew how to make a safeguarding alert, and did that when appropriate. There had been 24 safeguarding concerns raised with CQC between 31 August 2017 and 31 August 2018.

Staff worked closely with the local authority and police to ensure patients were protected from abuse and harm.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Relationships were good with the local authority who had visited the hospital to gain a better understanding of the service. Managers were trained to level three in safeguarding and were available to offer support to staff.

Staff access to essential information

Information needed to deliver patient care was not always easily available in one place. The service worked between electronic and paper based systems. Paper files contained risk assessments and care plans. A separate physical health file was in place which contained all health-related information. Progress notes were on the electronic system.

The service previously received hard copies of blood results but were now expected to obtain these electronically. The provider was attempting to gain access but as an interim measure the doctor was phoning the lab to obtain results. This had been raised as an issue and the head of care was attempting to resolve the issue.

Medicines management

Staff did not always follow good practice in medicines management. Patients were prescribed medicines to help with extreme episodes of agitation and anxiety. We saw there was a care plan in place and this listed the interventions in place before medicines were used. These plans referred to the use of 'when required medicines'. We saw two patients who were prescribed more than one 'when required' medicine for anxiety/ agitation. However, there was no guidance in place to state when each medicine would be used as detailed in the provider's 'when required' policy.

However, we found that medicine was stored safely and only accessible to staff authorised to handle medicines. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered.

A pharmacy contractor supplied medicines under a service level agreement; this included a weekly audit process.

Staff carried out medicine stock checks that reconciled the medicine stock with administration records. Some discrepancies in the records were identified by the pharmacy and nurse audit but it was not clear what action had been taken by staff to investigate and rectify these.

Track record on safety

There had been three serious incidents in the previous 12 months. All three incidents had taken place between July 2018 and August 2018. Two involved disruptive behaviour and one was a patient absconding. We reviewed the incident where the patient had absconded, and found that the hospital had made changes in response to this. This included increased security to the reception area.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Staff reported all incidents that they should report. Staff understood the duty of candour. They were open and transparent, and understood the need to give patients a full explanation when things went wrong.

Staff received feedback from investigations of incidents, both internal and external to the service. An internal bulletin was issued to staff and we saw evidence of learning from a recent incident. There had been increased security measures to the reception area in response to the incident.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient in a timely manner.

Staff assessed patient's physical health needs in a timely manner after admission. A full time junior doctor worked at the hospital and patients were registered with the local GP.

Staff developed care plans that met patients' needs and updated these regularly. However, care plans were not always changed to reflect the patient need. We found one patient who had been identified as being at risk of choking but no care plan was in place to reflect this. Care plans were in paper format and it was not always clear which was the current plan.

Best practice in treatment and care

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Staff provided a range of care and treatment interventions. Interventions included medicine and psychological therapies. The service had two occupational therapists and three activities coordinators. An activities timetable was available to patients; however, uptake to planned activities was low. There were restrictions to using communal areas since the opening of the acute ward. A small number of patients used the daily living kitchen to make their own meals but most used the onsite catering. The patient laundry room was also downstairs on the acute ward and patients could not access the gym, computer room and daily living kitchen until the afternoon.

Staff ensured that patients had good access to physical healthcare and were registered with a local GP and dentist. Patients were supported to attend the GP when required.

Staff supported patients to live healthier lives which included healthy eating, smoking cessation support, substance misuse support and access to exercise. However, we saw that attendance at groups was low and patients described being bored.

Staff used recognised rating scales to assess and record severity and outcomes.

Staff were unable to access blood test results online due to difficulty in obtaining an account. Results had previously been posted but now medical staff had to ring for the results. The head of care was attempting to resolve the issue.

Staff participated in clinical audit and an audit schedule was in place. This included a weekly audit of medicine and audit of searches.

Skilled staff to deliver care

The team included a full range of disciplines. This included a full-time doctor, junior doctor, nurses, support workers, psychologists, occupational therapists and activities therapists. The team was supported by a pharmacist who visited weekly.

Staff were experienced and qualified, however, there were some gaps in skills and knowledge as mandatory training figures were below compliance rates and staff were not trained in immediate life support. Staff could access specialist training for their role. Staff had undertaken specialist training in substance misuse and management of actual or potential aggression.

Managers provided staff with supervision. However, since the opening of the acute ward levels of supervision had decreased. Peer supervision took place monthly and was well attended. Team meetings had recently been reinstated, although there was no set agenda and limited evidence that actions from previous meetings had been progressed.

The percentage of staff that had an appraisal in the last 12 months was 93%.

The percentage of staff that received regular supervision was 83%. However, in September 2018 the figure was 53% and October 2018 was 58%.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers ensured that staff received the necessary specialist training for their roles.

Managers dealt with poor staff performance promptly and effectively. We saw examples of where complaints against staff had been fully investigated and dealt with.

Multi-disciplinary and inter-agency team work

Staff held daily multidisciplinary meetings. These were held each morning and were well attended, structured and informative. Patients risks were discussed and any changes to presentation. Discussions around discharge and links to care coordinators took place in the meetings. Staff shared information about patients in these meetings including any risks or concerns.

Care Programme Approach meetings were held every three months, families, care coordinators and any other relevant people were invited.

The service had effective working relationships with care coordinators, local GP, substance misuse teams and community mental health teams. There were good links with the local authority especially in relation to safeguarding and the local police.

Adherence to the MHA and the MHA Code of Practice

The mandatory training module included Mental Health Act, Mental Capacity Act and Deprivation of liberty safeguards. At the time of the inspection 64% of staff had had completed the training. Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of practice. The hospital had a dedicated Mental Health Act administrator.

The provider had relevant policies and procedures that reflected the most recent guidance and staff had easy access to these on the intranet.

Patients had easy access to information about independent mental health advocacy. A regular advocate visited the service twice a week and was present during the inspection. There were no concerns with the independent mental health advocacy service and the hospital referred all patients to this service. However, we found that information on the local advocacy service not commissioned by the provider was not available.

Staff explained to patients their rights under the Mental Health Act as required by section 132 in a way that they understood. This was done at the time of admission and three-monthly after this. However, we found three records where this was not completed at the time of admission to the hospital. For those patients who frequently refused this information there was no plan in place of how to address this or safeguard the patient. We found one patient had refused this information for 10 months.

Staff ensured that patients could take Section 17 leave (permission for patients to leave hospital) when this has been granted. Staff stored copies of patients' detention documentation and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.

Where detained patients had been receiving treatment in hospital for their mental disorder for three months, the responsible clinician requested a second opinion appointed doctor to authorise treatment or had completed a T2 form to authorise treatment. The responsible clinician had changed the treatment plan of some patients and had completed a section 62 form. Section 62 is used while waiting for a second opinion appointed doctor visit or in emergency situations. We found some T2 and section 62 forms did not detail the route of administration for the medication.

Certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised (section 62 or T3) were completed and located in the dispensing room where the prescription charts were located. We found old forms were present with prescription charts which made it difficult to be sure which medication was authorised. This could lead to mistakes when administering medication to patients. We found not all prescribed medication was authorised. This is a breach of the MHA. We gave feedback of our concerns to the head of care on the first day of our visit.

Good practice in applying the MCA

We found that 64% of staff had had training on the Mental Capacity Act.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it and knew where to get advice from.

Staff gave patients every possible assistance to make a specific decision for themselves. Patients were supported to manage their finances.

Patients' care and treatment records contained evidence of capacity assessments. These were all related to consent to treatment decisions. The assessments contained clear documentation of the capacity assessment completed and the rationale on the outcome whether a patient was assessed as having or lacking capacity to consent to treatment.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with and discussing patients showed that they were discreet, respectful and responsive. Staff provided patients with help, emotional support and advice at the time they needed it. Staff discussed the specific needs of patients individually in morning handover meetings, and worked together to respond to the daily changing needs of

patients. However, when we spoke with patients, they told us that the attitudes and behaviours displayed by the full-time staff were not always shared with agency staff, who were not always as friendly.

Staff supported patients to understand and manage their care, treatment or condition. Patients were discussed daily in morning handover meetings where staff discussed different treatment options that patients could consider moving forward.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. Staff discussed referring patients to other services during ward rounds. Discussions took place around referring patients to other voluntary organisations such as support for drug misuse.

Patients said staff treated them well and behaved appropriately towards them. Patients told us that staff were polite, respectful and caring towards them and that they felt that staff were also genuinely invested in their wellbeing. However, patients had differing opinions of agency staff who they felt were not as nice as the regular full-time staff. Patients did not feel that agency staff spoke to them. The independent mental health advocate confirmed that since the changes to the hospital and the increased use of agency staff that they found not all staff introduced themselves.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. This was reflected within patient care plans that outlined the full range of patient's individual needs, and were personalised to the individual. Staff were aware of the provider Equality and Diversity policy, but were unable to explain how this has been implemented on the ward and in every day practice. Staff were unsure about the availability of different methods of communication e.g. translators, as these had not been required previously on the ward.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Staff were aware of the complaints procedure, as well as the whistleblowing policy. All staff we spoke with said they would feel confident in raising concerns.

Staff maintained the confidentiality of information about patients.

Involvement in care

Staff used the admission process to inform and orient patients to the ward and to the service.

Each patient had an individual care plan and these were regularly reviewed. However, we found some care plans had not been reviewed to reflect changes. Some patients told us that they had not seen copies of their care plan, whilst others commented that they were unsure.

We found that care plans were very long. Patient goals were not always clear and It was not always clear what the patient thought of their care and treatment.

Staff found effective ways to communicate with patients with communication difficulties. Staff had tried to represent and incorporate patient views into care plans. Patients were encouraged to complete self-assessments that formed parts of their care plan. We saw records of one-to-one sessions between patients and staff. We saw patients could attend multidisciplinary reviews if they chose to. We found patient views were recorded in most care programme approach meeting minutes.

Staff involved patients when appropriate in decisions about the service. However, patients had raised concerns about the acute ward and did not feel listened to. The hospital involved patients in staff recruitment and conducted an annual survey. This feedback was reviewed by staff members, and raised with senior managers in the organisation.

Staff ensured patients could access advocacy.

Involvement of families and carers

Staff informed and involved families and carers where appropriate. Patients were asked about family involvement when they came into the service and consent was obtained to contact loved ones. A monthly carers clinic was available. The clinic gave families and carers the opportunity to ask questions about the hospital, ask about their loved one's treatment and for them to give feedback on the service.

The psychologist took the lead for working with families and carers and was in the process of identifying what support was available in local communities. Information was given to families on how to access a carers assessment.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access and discharge

Average bed occupancy over the last 12 months was 69%. There had been no patients admitted in the last six months. Patient were staying for an average of two and a half years which was longer than expected in a high dependency unit.

The service took referrals from across the country and worked closely with the home teams. The service was not at capacity so there were currently seven available beds for new referrals. Referrals to the rehabilitation ward had decreased significantly to the hospital.

There was always a bed available when patients returned from leave.

A bed could be found on a psychiatric intensive care unit from within the providers provision. Internal transfers were prioritised.

In the last 12 months there had been one delayed discharge. This was because there was not an appropriate community setting in which to place the patient concerned.

Staff discussed patients discharge in multidisciplinary meetings but we did not see evidence of discharge plans. The discussions around discharge were taking place and contained within progress notes. There was evidence of liaison with care managers/co-ordinator's.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms which they could personalise. Patients could store their possessions safely.

Staff and patients had access to a range of rooms and equipment, which included a clinic room, activities room, gym and computer space. However, access to the rooms was restricted since the opening of the acute ward on the ground floor. The rehabilitation patients had lost the free access to the dining room, gym and activities room. The communal lounge was now located upstairs and did not allow easy access to the garden.

There were quiet areas on the ward and a room where patients could meet visitors. A telephone was available to patients on the ward but most had their own mobile phones.

Patients had access to an outside space. The space had been reduced since the opening of the acute ward and most patients used the area to smoke. All patients had access to outside space through an unlocked staircase.

The food was of a good quality and patients could make hot drinks and snacks 24/7. There was a patient kitchen on the ward which was locked and the patients had individual keys. Each patient was individually risk assessed before being given a key.

Patients' engagement with the wider community

Staff attempted to support patients to access education and work opportunities. We saw evidence in patients' care records that the hospital's occupational therapist helped patients to access education and work opportunities. However, we found that few patients engaged in constructive activities.

Staff supported patients to maintain contact with families and carers. With permission contact was made with family on admission. A monthly carers clinic took place where family members were given a timeslot to call the service and discuss any issues or concerns they had. Members of the team were available if there were specific issues the family wanted to discuss.

Meeting the needs of all people who use the service

The service had made adjustments for disabled patients and a lift was available. However, the ward was located on the first floor of the building and the lift opened onto the acute ward. A patient had been assessed as requiring ground floor accommodation but was still on the first floor as no ground floor accommodation was available in the rehabilitation service.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Patients communication needs were assessed and reviewed. Information could be made available in different formats dependant on the patient. Managers ensured that staff had access to interpreters and signers.

Patients were asked about dietary requirements when they were admitted and this was catered for. Patients had access to a multi faith room and the service had links with local services to ensure peoples religious and spiritual needs were met. Patients were supported to link with communities to support their sexuality and there had been involvement from the hate crime police officer to raise awareness of issues.

Listening to and learning from concerns and complaints

There had been nine complaints made to the service in the previous 12 months, one was upheld. No complaints had been referred to the Ombudsman.

Patients knew how to complain or raise concerns and were given feedback. We reviewed two complaints and found that the provider had followed the policy.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to handle complaints appropriately.

Staff received feedback on the outcome of investigation of complaints and acted on the findings.

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Are long stay/rehabilitation mental health wards for working-age adults well-led?

Requires improvement

Leadership

Leaders had the skills, knowledge and experience to perform their role. Since the opening of the acute ward there had been some management changes and a period of uncertainty. However, the hospital was regaining stability with the appointment of a new hospital manager. The previous hospital manager was now working in a new role covering the three hospitals in the area as deputy manager.

Leaders had a good understanding of the service, although this was not always communicated and understood by all staff working below them.

Leaders were visible in the service and approachable for patients and staff.

Leadership development opportunities were available, the provider offered an apprenticeship leadership programme. Support workers could access an associate nurse training programme if they wanted to progress into nursing.

Vision and strategy

Staff knew and understood the providers vision and values and how they applied to their work. These were displayed on intranet screens and on notice boards. However, since the opening of the acute ward there was a high use of agency staff who did not understand the vision and values. A booklet was being developed for all new staff including agency to give an awareness and understanding of the provider and the hospital.

Staff had been involved in discussion about the opening of the acute ward. Staff and manages had expressed concern at the timeframe in which the acute ward was opened. This had not changed the timeframe in which the acute ward had opened and there had been a negative impact on the rehabilitation ward.

Culture

Staff felt respected, supported and valued. Staff felt positive and proud about working for the provider and their team. However, there had been a significant change to staffing since the opening of the acute ward. Some staff who had left the service were now retuning onto the bank.

Staff understood the whistleblowing policy and felt able to raise concerns without fear of retribution.

Managers dealt with poor staff performance when needed and we saw evidence of where this had taken place. There were currently four staff suspended.

The team worked well together and staff supported both wards. There was separate nursing and support staff for each ward but members of the multi-disciplinary team such as psychology and occupational health staff worked across both. Staff helped when needed to ensure the safe running of the service. Staff were supported to look at career progression this included managers and other staff.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Managers could give examples of where the provider promoted equality and diversity in their day to day work. However, some staff were unable to communicate how they offered a fair service to all.

Staff had access to support for their own physical and emotional needs. An employee assistance helpline and counsellor sessions were available to staff.

The provider recognised staff success through employee of the month and awards to staff. Staff complaints were raised in the morning meetings.

Governance

There was a clear framework of what must be discussed within the service. This included learning from incidents and complaints. Discussions were also taking place around the running of the two separate wards within the hospital. This had created a period of uncertainty at the hospital and managers were making attempts to regain stability. Morning handover meetings took place for each ward and these were the central point of discussions around the day to day running of the service.

Staff had implemented recommendations from reviews. We saw that stricter security measures had been made to the reception area in response to an incident. We saw a number of blanket restrictions which had not been reviewed and had remained unchanged for over one year.

Staff took part in local clinical audits and action plans had been developed to improve the hospital.

Staff understood the need to work with other teams. We saw discussions taking place in the morning handover meetings about working with local housing providers and commissioners.

Management of risk, issues and performance

Staff maintained and had access to a risk register. Concerns could be escalated to the provider when needed. Concerns around the opening of the acute ward had been escalated. Managers were currently in discussion with senior managers about the future of the hospital.

A business continuity plan was in place in the event of emergencies.

Cost improvements had taken place to the hospital when the acute ward opened. Managers could manage the budget of the service to meet the needs of service users.

Information management

The service used systems to collect data which was analysed centrally by the provider and sent to local managers in a monthly data pack.

Staff had access to the equipment and information needed to do their work. However, the service was currently working between paper files and an electronic system. Permanent staff knew where information was stored but we found that this could be in several places and was not consistent.

Information governance systems included confidentiality of patient records. Paper files were stored in a locked cabinet.

Managers had access to information to support them with their management role. Performance information was received centrally and this was easy to understand. Managers had action plans in place for areas which they needed to improve upon.

The service made notifications to external bodies such as CQC, Local Authority and the police.

Engagement

Staff and patients had access to up to date information about the provider through bulletins and on the intranet. Carers booklets were not yet available but carers could get information through monthly carers clinics.

Patients and carers could give feedback on the service through surveys, community meetings and by speaking to staff. The hospital was in the process of setting up a people council to give patients a greater involvement in the running of the hospital.

Patients and carers had not been involved in the decision to change the hospital. Patients were unhappy about the space they had lost due to the opening of the acute ward. The patient's communal area had previously been on the ground floor opening onto the garden and was well used. Since they had moved upstairs few patients accessed the communal living area.

Learning, continuous improvement and innovation

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Staff were given the time and support to consider opportunities for improvements and innovation. The hospital psychologist was the research lead for the organisation.

Staff were participating in research which included mindfulness for staff and a mindfulness tracker for patients. The service was also doing research into the impact the changes to the hospital were having upon staff. The provider had its own research group that was researching the use of chat cafes, engagement with patients and the model of human sociality.

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Innovative practices included the use of eye movement desensitisation and reprocessing. This is a form of psychotherapy in which the person being treated is asked to recall distressing images while generating one type of bilateral sensory input, such as side-to-side eye movements or hand tapping.

The provider used quality improvement methodologies. These included the recruitment of an expert by experience to highlight the patient experience to the board, the development of information technology systems to support the measurement of outcomes of patient care and the development of a nurse preceptorship training programme.

The ward had been aims accredited until November 2019.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all restrictions in the environment are based on an individual assessment of risk and are documented and reviewed.
- The provider must ensure that all risks identified are risk managed appropriately to ensure the safety of all patients
- The provider must ensure that staff are up to date with mandatory training.
- The provider must ensure that medicines are properly authorised under the Mental Health Act.
- The provider must ensure that all qualified medical and nursing staff are trained in immediate life support.

Action the provider SHOULD take to improve

- The provider should continue to ensure that vacancies are recruited to.
- The provider should ensure that all information relating to patients care and treatment is easily accessible to all staff.
- The provider should ensure that staff receive regular supervision.
- The provider should review information available for medicines prescribed when required to ensure it is in line with the provider's policy
- The provider should ensure that information about independent mental health advocacy is available to patients
- The provider should review the restrictive layout of the ward and ensure that activities meet the needs of patients.
- The provider should ensure that all agency staff have an induction and have the skills and qualities to work at the hospital.
- The provider should ensure that discussions around discharge are documented in a discharge plan.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks such as choking had been identified but risk management plans were not in place. There was no care plan to say how this risk should be managed. We reviewed consent to treatment documentation for 13 patients and found medicines for four patients were not prescribed in accordance with the Mental Health Act.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not up to date with mandatory training. Staff were not receiving immediate life support training.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not always delivered on individual need. Blanket restrictions were in place on both wards that were not reviewed.